Tankersley Chiropractic

165 Indian Lake Blvd., Suite 102 • Hendersonville, TN 37075
Phone: (615) 826-7889

CONFIDENTIAL PATIENT HEALTH HISTORY

(please fill out in legible writing)

Today's Date: _____

Name: _____ Nickname: _____
Last First Middle

Address: _____

City _____ State _____ Zip_____

Home Phone: _____ Cell Phone: _____

Cell Phone Carrier (AT&T, Verizon, T-Mobile) : _____

Spouse Name: _____ Phone: _____

Social Security #: _____ Gender: Male Female

Marital Status: _____ Race/Ethnicity: _____

Date of Birth: _____ Email Address: _____

Occupation: _____

Employers Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

How would you like to receive appointment reminders? Email Text message

Have you ever seen a Chiropractor before? Yes No

Last visit date? _____ Chief Complaint: _____

Whom may we thank for referring you to our office? _____

List any medications you are taking or please provide a list on your next visit: _____

_____

Smoking Status: daily / occasionally / former / never

Authorization to treat:
I understand that no guarantees have been made concerning my recovery as every individual responds to Chiropractic differently. I hereby authorize Tankersley Chiropractic and whomever they may designate as an assistant to administer therapies and take x-rays if needed. I have read and understand the office policy stated above and agree to accept responsibility as described.

Patient/Guardian Signature: _____ **Date:** _____

Guardian Name (printed) **:** _____

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Authorization to release insurance and treatment information

I hereby instruct and authorize my insurance company to release information concerning my coverage and benefits for both health/auto insurance and pay by check made out and mailed directly to: Tankersley Chiropractic, 165 Indian Lake Blvd., Suite 102 Hendersonville, TN 37075.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I authorize Tankersley Chiropractic to release and gather any or all my medical records as deemed necessary to/from other health care providers. I also authorize release of records to my insurance company as requested to facilitate payment to Tankersley Chiropractic. I understand this office will take all necessary precautions to insure my privacy. I have been given a copy of the HIPAA regulations for my review.

I understand that my account is considered delinquent if over 90 days old and may be sent to an outside source for collection. I agree that if Tankersley Chiropractic initiates collection efforts to recover amounts owed on my account, then, in addition to amounts owed for the services rendered, I will pay any and all costs incurred by Tankersley Chiropractic in pursuing collection, including, but not limited to, reasonable attorney fees, and any court costs or other costs of litigation incurred in collecting my delinquent account.

I have read and understand the office policy stated above and agree to accept responsibility as described.

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. By signing below, I acknowledge that I have been made aware of its availability.

Patient/Guardian Signature: _____ **Date:** _____

Guardian Name (printed) **:** _____

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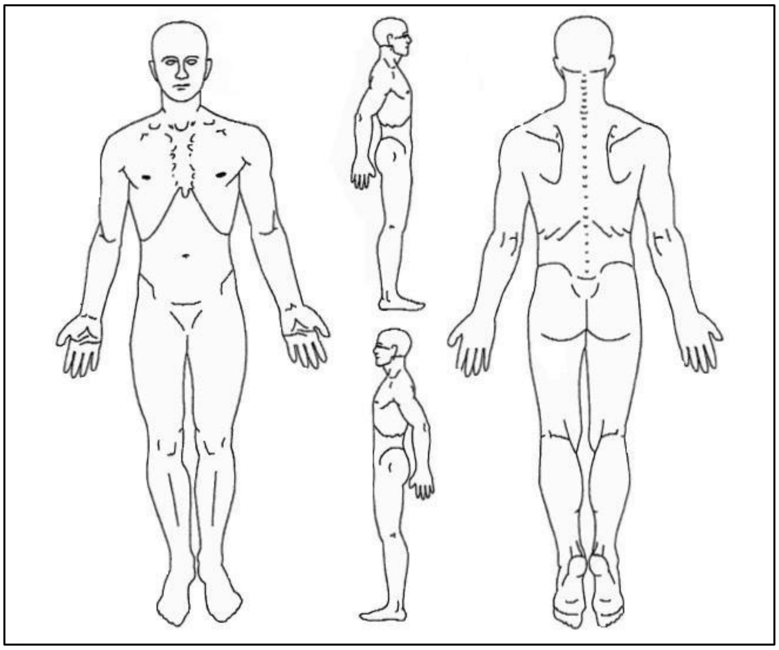
Subjective Pain Questionnaire

Name: ____ Date:________________



Mark each area of pain or complaint and use the boxes below to describe you condition.

On a scale of 1-10 with 10 being severe, rate your pain, stiffness, or numbness below.

Area of pain:

Type of Pain: Sharp Stabbing Burning Achy Dull Stiff & Sore
Frequency: Constant Off/On (if off / on answer next question)
If off & on, I feel it ________ (1, 2, 5 x's) per Day, Week, Month
Radiate: Y / N Where does it radiate? ______________________________
Better: Ice Heat Rest Movement Stretching Medication Other
Worse: Sit Stand Walk Lying Sleeping Bending Working Overuse AM PM All

Pain At Its **Best**: 0 1 2 3 4 5 6 7 8 9 10 Pain At Its **Worse**: 0 1 2 3 4 5 6 7 8 9 10

Area of pain:

Type of Pain: Sharp Stabbing Burning Achy Dull Stiff & Sore
Frequency: Constant Off/On (if off / on answer next question)
If off & on, I feel it ________ (1, 2, 5 x's) per Day, Week, Month
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Pain At Its **Best**: 0 1 2 3 4 5 6 7 8 9 10 Pain At Its **Worse**: 0 1 2 3 4 5 6 7 8 9 10

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Pain At Its **Best**: 0 1 2 3 4 5 6 7 8 9 10 Pain At Its **Worse**: 0 1 2 3 4 5 6 7 8 9 10

Other areas of concern: ____

____

Name: _____ Date: _____

Many of the following conditions respond to Chiropractic and Acupuncture treatment
please check all that apply

General: (constitutional)
- ❑ Recent Weight Change
- ❑ Fever
- ❑ Fatigue
- ❑ ***None in this Category***

Musculoskeletal:
- ❑ Low Back Pain
- ❑ Mid Back Pain
- ❑ Neck Pain
- ❑ Arm Problems _____
- ❑ Leg Problems _____
- ❑ Painful Joints _____
- ❑ Stiff/Swollen Joints
- ❑ Sore/Weak Muscles or Joints
- ❑ Muscle Spasms/Cramps
- ❑ Broken Bones _____

_____
- ❑ Other: _____
- ❑ ***None in this Category***

Neurological:
- ❑ Numbness or tingling sensations
- ❑ Loss of Feeling
- ❑ Dizziness or light headed
- ❑ Frequent or Recurrent Headaches
- ❑ Convulsions or seizures
- ❑ Tremors
- ❑ Stroke
- ❑ Have you ever had a head injury?
- ❑ **Ever** been in an auto accident?
- ❑ Date of last accident?

_____
- ❑ Other: _____
- ❑ ***None in this Category***

Mind/Stress:
- ❑ Nervousness
- ❑ Depression
- ❑ Sleep Problems
- ❑ Memory Loss or Confusion
- ❑ Other: _____
- ❑ ***None in this Category***

Genitourinary:
- ❑ Sexual Difficulty
- ❑ Frequent Urination

Genitourinary Cont. :
- ❑ Incontinence or Bed Wetting
- ❑ Other: _____
- ❑ ***None in this Category***

Gastrointestinal:
- ❑ Loss of Appetite
- ❑ Change in Bowel Movements
- ❑ Painful Bowel Movements
- ❑ Nausea or Vomiting
- ❑ Abdominal Pain
- ❑ Frequent Diarrhea
- ❑ Constipation
- ❑ Other: _____
- ❑ ***None in this Category***

Cardiovascular & Heart:
- ❑ Chest Pains
- ❑ Rapid or Heartbeat changes
- ❑ Blood Pressure Problems
- ❑ Swelling of Hands, Ankles, or Feet
- ❑ Heart Problems
- ❑ Other: _____
- ❑ ***None in this Category***

Respiratory:
- ❑ Difficulty Breathing
- ❑ Persistent Cough
- ❑ Coughing Blood
- ❑ Asthma or Wheezing
- ❑ Lung Problems
- ❑ Other: _____
- ❑ ***None in this Category***

Eyes and Vision:
- ❑ Blurred or double vision
- ❑ History of Ocular Migraines
- ❑ Eye disease or injury
- ❑ Other: _____
- ❑ ***None in this Category***

Ears, Nose and Throat:
- ❑ Swollen throat or voice change
- ❑ Swollen glands in neck
- ❑ Ringing in the ears

Ears, Nose and Throat Cont. :
- ❑ Ear – Ache / Ringing
- ❑ Ear Drainage
- ❑ Sinus / Allergy problems
- ❑ Hearing Loss
- ❑ Other: _____
- ❑ ***None in this Category***

Endocrine, Hematologic, and Lymphatic:
- ❑ Thyroid problems
- ❑ Diabetes
- ❑ Excessive Thirst or urination
- ❑ Cold Extremities
- ❑ Heat or Cold intolerance
- ❑ Change in hat or glove size
- ❑ Dry skin
- ❑ Glandular or hormone problem
- ❑ Swollen Glands
- ❑ Anemia
- ❑ Easily Bruise or Bleed
- ❑ Phlebitis
- ❑ Immune system disorder
- ❑ Other:
- ❑ **None *in this Category***

Skin and Breasts:
- ❑ Rash or Itching
- ❑ Change in Skin Color
- ❑ Change in hair or nails
- ❑ Non-healing sores
- ❑ ***None in this Category***

Women Only:

Are you pregnant?
- ❑ Yes Due Date: _____
- ❑ No

Last Menstrual Period: _____
- ❑ Infertility
- ❑ Painful or Irregular periods
- ❑ Other: _____
- ❑ ***None in this Category***

Number of Children _____